MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

DATA CLARIFICATIONS FOR THE 837 PROFESSIONAL ENCOUNTER, VERSION 4010

July 8, 2002
(Revised November 22, 2002)

Michigan Department of Community Health
MDCH

MSA
MEDICAL SERVICES ADMINISTRATION

This document is intended as a companion to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional, ASC X12N 837 (004010X098)**, dated May 2000. It contains data clarifications authorized by the Department of Health and Human Services on September 17, 2001. The clarifications include:

- identifiers to use when a national standard has not been adopted [and]
- parameters in the implementation guide that provide options

Encounter data submitted to the Michigan Department of Community Health (MDCH) will be handled using the 837 transaction Provider-to-Payer-to-Payer Coordination of Benefits (COB) data model. Follow the Implementation Guide instructions for COB reporting guidelines.

(The implementation guide can be found at http://www.wpc-edi.com/hipaa/hipaa_40.asp. HHS guidance on data clarifications can be found at http://aspe.os.dhhs.gov/admnsimp/q0321.htm.)

November 22, 2002 revisions to the Data Clarifications for the 837 Professional Encounter, Version 4010, dated July 8, 2002 include:

1. Updated Comment fields for:
    - Loop 2010BA NM109 – Subscriber Primary Identifier (Page 2)
    - Loop 2330B NM109 – Other Payer Primary Identifier (Page 4)

September 16, 2002 revisions to the Data Clarifications for the 837 Professional Encounter, Version 4010, dated July 8, 2002 include:

1. Updated Comment fields for:
    - Loop 2000B SBR09 – Claim Filing Indicator Code (Page 2)
    - Loop 2010BA NM109 – Subscriber Primary Identifier (Page 2)
    - Loop 2320 Segment SBR – Subscriber Information (Page 3)
    - Loop 2320 SBR05 – Insurance Type Code (Page 3)
    - Loop 2320 SBR09 – Claim Filing Indicator Code (Page 4)
2. Added Data Element:
    - Loop 2000B SBR04 – Insured Group Name (Page 1)

Page	Loop	Segment	Data Element	Comments
65		BHT – (Header) Beginning of Hierarchical Transaction	BHT06 – Transaction Type Code	Use “RP” – Reporting.
66		REF – (Header) Transmission Type Identification	REF02 – Transmission Type Code	Use “004010X098” if using May 2000 Implementation Guide.
69	1000A – Submitter Name	NM1 – Submitter Name	NM109 – Submitter Identifier	Use the 4-character billing agent ID assigned by MDCH.
75	1000B – Receiver Name	NM1 – Receiver Name	NM109 – Receiver Primary Identifier	Use “D00111” for MDCH.
86	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM108 – Identification Code Qualifier	Use “24” or “34”.
86	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM109 – Billing Provider Identifier	If the provider has an assigned MDCH provider ID, the SSN or EIN reported here must correspond to that assigned ID.
92	2010AA – Billing Provider Name	REF – Billing Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” unless the provider does not have a Medicaid ID, then use “0B”.
92	2010AA – Billing Provider Name	REF – Billing Provider Secondary Identification	REF02 – Billing Provider Additional Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider use their state license number.
108	2000B – Subscriber Hierarchical Level	HL		MDCH accepts a maximum of 5,000 CLM segments in a single transaction (ST-SE), as recommended by the HIPAA-mandated implementation guide.
110	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	To identify MDCH’s level of responsibility use “S” if the capitated plan is the only payer (that is, patient has no other insurance), “T” if there are any other payers.
100	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR04 – Insured Group Name	Use “MICHILD” for children enrolled in the MIChild Program.

Page	Loop	Segment	Data Element	Comments
112	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR09 – Claim Filing Indicator Code	Use "MC" for Michigan Medicaid, "TV" for CSHCS (Title V), "OF" (Other Federal) for MIChild, or "11" for State Medical Plan or for persons who are not enrolled in Medicaid (Other Non-Federal). If recipient qualifies for more than one program, or other MDCH program not listed, use "MC".
119	2010BA – Subscriber Name	NM1 – Subscriber Name	NM108 – Identification Code Qualifier	Use "MI".
119	2010BA – Subscriber Name	NM1 – Subscriber Name	NM109 – Subscriber Primary Identifier	Use the patient's 8-digit member ID number assigned by MDCH. For MIChild enrollees use the 8-digit Client Identification Number (CIN) assigned by the enrollment broker. For other persons who are not enrolled in Medicaid or MIChild, use the patient's Social Security Number. Use the capitated plan's unique identifier assigned to the patient **only** when the person is not enrolled in Medicaid or MIChild and the Social Security Number is unknown.
126	2010BA – Subscriber Name	REF – Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Use "SY".
127	2010BA – Subscriber Name	REF – Subscriber Secondary Identification	REF02 – Subscriber Supplemental Identifier	Use the patient's Social Security Number. Report this value even when used in NM109 – Subscriber Primary Identifier.
131	2010BB – Payer Name	NM1 – Payer Name	NM108 – Identification Code Qualifier	Use "PI".
131	2010BB – Payer Name	NM1 – Payer Name	NM109 – Payer Identifier	Use "D00111" for MDCH.
170	2300 – Claim Information	CLM		Note that the HIPAA-mandated implementation guide allows a maximum of 100 repetitions of the 2300 CLM loop within each patient/subscriber loop.
217	2300 – Claim Information	CN1 – Contract Information	CN101 – Contract Type Code	Use "05" when plan has a capitated arrangement with the billing provider.
265	2300 – Claim Information	HI – Health Care Diagnosis Code	HI01 – Principal Diagnosis	MDCH requires this element on every encounter.
288	2310A – Referring Provider Name	REF – Referring Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use "1D" unless the provider does not have a Medicaid ID, then use "0B".

Page	Loop	Segment	Data Element	Comments
289	2310A – Referring Provider Name	REF – Referring Provider Secondary Identification	REF02 – Referring Provider Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.
292	2310B – Rendering Provider Name	NM1 – Rendering Provider Name	NM108 – Identification Code Qualifier	Use “24” or “34”.
292	2310B – Rendering Provider Name	NM1 – Rendering Provider Name	NM109 – Rendering Provider Identifier	If the provider has an assigned MDCH provider ID, the SSN or EIN reported here must correspond to that assigned ID.
296	2310B – Rendering Provider Name	REF – Rendering Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D” unless the provider does not have a Medicaid ID, then use “0B”.
297	2310B – Rendering Provider Name	REF – Rendering Provider Secondary Identification	REF02 – Rendering Provider Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID); if the provider is not a Medicaid provider, use their state license number.
319	2320 – Other Subscriber Information	SBR – Subscriber Information		This loop will be used once for the capitated plan and once for each other payer. Community Mental Health encounters will require this loop once for the Prepaid Health Plan (PHP), once for the Community Mental Health Service Program (CMHSP) Affiliate, and once for each other payer.
319	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	If the patient has Medicare or other insurance, report that coverage with code “P” or “S”, as appropriate, and the capitated plan coverage with “S” or “T”, as appropriate. If the patient has no other insurance, report the capitated plan coverage with “P”.
319	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR02 – Individual Relationship Code	The code carried in this element is the patient’s relationship to the person who is insured. For example, if a child with Medicaid also has coverage under the father’s insurance, use code “19” (Child).
320	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR03 – Insured Group or Policy Number	Use the subscriber’s group number (assigned by the capitated plan or other payer), not the number that uniquely identifies the subscriber. For example, group numbers assigned by BCBSM are usually 5 digits.
321	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR05 – Insurance Type Code	Community Mental Health encounters should report “MC” for Medicaid Fund and “OT” (Other) for General Fund.

Page	Loop	Segment	Data Element	Comments
321	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR09 – Claim Filing Indicator Code	Community Mental Health encounters should report "MC" for Medicaid Fund and "11" (Other Non-Federal) for General Fund.
350	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM103, NM104, NM105, NM107 – Other Insured Last Name, First Name, Middle Name, Suffix	Use the name of the subscriber as it appears on the files of the capitated plan or other payer.
352	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM108 – Identification Code Qualifier	Use "MI".
352	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM109 – Other Insured Identifier	Use the unique member number assigned to the subscriber by the capitated plan or other payer indicated in loop 2330B. For example, member numbers assigned by BCBSM are usually 3 letters followed by 9 digits.
357	2330A – Other Subscriber Name	REF – Other Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Do not use "1W".
360	2330B – Other Payer Name	NM1 – Other Payer Name	NM108 – Identification Code Qualifier	Use "PI".
361	2330B – Other Payer Name	NM1 – Other Payer Name	NM109 – Other Payer Primary Identifier	For the capitated plan, use the 9-digit Payer ID assigned by MDCH. For other payers, use the carrier code assigned by MDCH (see MDCH website for listing of carrier codes). For example, if BCBSM Traditional were the Other Payer, the value (carrier code) carried in this element would be "00029005". For Medicare Part A (United Government Services) use "00452". For Medicare Part B (Wisconsin Physician Services) use "00953".
368	2330B – Other Payer Name	REF – Other Payer Secondary Identification	REF01 – Reference Identification Qualifier	For the capitated plan, use "F8".
369	2330B – Other Payer Name	REF – Other Payer Secondary Identification	REF02 – Other Payer Secondary Identifier	For the capitated plan, enter the plan-assigned unique identifier (encounter reference number) for the encounter.
370	2330B – Other Payer Name	REF – Other Payer Prior Authorization or Referral Number	REF01 – Reference Identification Qualifier	Use "9F" or "G1".

Page	Loop	Segment	Data Element	Comments
371	2330B – Other Payer Name	REF – Other Payer Prior Authorization or Referral Number	REF02 – Other Payer Prior Authorization or Referral Number	If the capitated plan or other payer pre-authorized services or a referral, enter the authorization number or referral number here. Do not use the Prior Authorization or Referral Number segment in the 2300 loop (which is specific to the destination payer).
380	2330D – Other Payer Referring Provider	REF – Other Payer Referring Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D”.
384	2330E – Other Payer Rendering Provider	REF – Other Payer Rendering Provider Secondary Identification	REF01 – Reference Identification Qualifier	Do not use “1D”.
388	2330F – Other Payer Purchased Service Provider	REF – Other Payer Purchased Service Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D”.
392	2330G – Other Payer Service Facility Location	REF – Other Payer Service Facility Location Identification	REF01 – Reference Identification Qualifier	Do not use “1D”.
396	2330H – Other Payer Supervising Provider	REF – Other Payer Supervising Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D”.
398	2400 – Service Line			The HIPAA Implementation Guide allows up to 50 repetitions of the 2400 Service Line Loop for each 2300 loop.
401	2400 – Service Line	SV1 – Professional Service	SV101-2 – Procedure Code	For Community Mental Health and Substance Abuse services, see the MDCH Crosswalk Between Service Use/Encounters Per Consumer (refer to MDCH website for HIPAA Codes for Mental Health and Substance Abuse Procedures).
554	2430 – Line Adjudication Information			MDCH expects this loop to be populated for each payer identified in loop 2330B that has adjudicated this claim and applied service line adjustments.